## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  R-C 02/04/2014	
		155215	B. WING				
NAME OF PROVIDER OR SUPPLIER		100210		STREET ADDRESS, CITY, STATE, ZIP CODE		02/	04/2014
INAIVIE OF FI	NOVIDER OR SUFFLIER						
PLAINFIELD HEALTH CARE CENTER				3700 CLARKS CREEK RD PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	00) INITIAL COMMENTS		{F 0	000}			
	and complaint IN001 December 23, 2013.	21, complaint IN00141411, 41521 completed on					
	Review Date: February 4, 2014						
	Facility number: 000						
	Provider number: 155215 AIM number: 100290940						
	Surveyor: Brenda Marshall, RN						
	compliance with 42 C	e Center was found to be in CFR Part 483, subpart B and ard to the paper compliance int investigation.					
L ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RF		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.